Late Policy...

We request that you arrive in the clinic **at least 15 minutes** prior to your scheduled time to fill out or clarify insurance papers and referrals. This will allow our nursing staff to get you comfortable into an examination room by the time of your scheduled appointment.

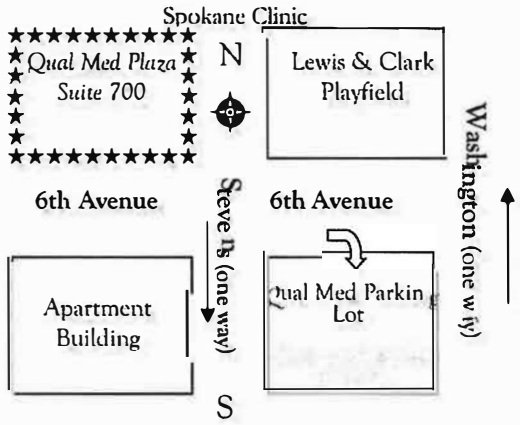
If you arrive significantly later than your scheduled appointment (i.e. **15 minutes late or more**), you will be considered a "work-in" patient and will be seen as the provider's schedule allows. If there is no time available for the duration of your provider's scheduled session, the clinical team will work with you to provide the best alternative, or to reschedule for another day.

No Show Policy...

If you fail to show up for your scheduled visit there will be a $50.00 fee.

Directions...

Travel south on Stevens, turn left on Sixth Avenue. Parking is in the Qual Med Parking Lot . We are located "kitty corner" in the Qual Med Plaza, Suite 700. **Handicap Parking is available in front of our building.**



Our Information...

Spokane: 508 West Sixth Avenue, Suite 700
Spokane, WA 99204
(509) 747-1624 Phone
(509) 747-6774 Fax

Colfax: 3 Forks Orthopedic Clinic
1200 W Fairview
Three Forks Building

Pullman: 825 SE Bishop Blvd. Suite 140

www.spokaneallergy.com

Spokane Allergy & Asthma Clinic

Our Mission Statement...

The Spokane Allergy & Asthma Clinic is committed to providing the highest quality individualized care possible, utilizing the most current knowledge and technology, provided by our team of skilled professionals.

SPOKANE ALLERGY and ASTHMA CLINIC

Please **PRINT clearly:** **Today's date:** ___/___/___

Patient Information: ___ New patient ___ Name change ___ Address change ___ Insurance change

Patient Name: _____

SSN#: _____/_____/_____ Date of Birth: _____/_____/_____ Age: _____ Sex: ___ male ___ female

Home Address: _____City_____State___ Zip_____
Mailing Address: if different: _____

Phone: Which number do you prefer we call first? ___ Home ___ work ___ cell ___ message
Home: (_____) _____-_____ Work: (_____) _____-_____ Cell: (_____) _____-_____ Mess: (_____) _____-_____
E-mail: _____

PARENT, SPOUSE, OR RESPONSIBLE PARTY (if different from patient)
Name: _____ Social Security #_____
Date of Birth: _____/_____/_____
Address: _____City_____State___Zip_____
Home Phone: (_____) _____-_____ Work phone: (_____) _____-_____ Cell: (_____) _____-_____
Relationship to Patient: _____

PAYMENT POLICY
The Adult or Guardian, who brings in the patient if a child, will be responsible for **all** copayments and deductibles. Spokane Allergy and Asthma Clinic will **not** forward bills to other parties, regardless of court rulings or divorce decrees.

PRIMARY INSURANCE COVERAGE:

Insurance Company Name: _____ Policy Type: ___ HMO ___ PPO

Address of Claim Center: _____City_____State___ Zip_____

Member ID #: _____Group Name or ID#:_____
The following is **REQUIRED if the insured is not the subscriber of the insurance.

Name of Subscriber: _____ Subscriber's ID #: _____

Subscriber Address_____

Subscriber's SSN#: _____/_____/_____ Subscriber's Date of Birth: _____/_____/_____

Relationship to insured: ___ Self ___Mother ___Father ___ Spouse ___ other

SECONDARY INSURANCE COVERAGE:
Insurance Company Name: _____ Policy Type: ___ HMO ___ PPO
Address of Claim Center: _____City _____State ___ Zip _____

Member ID #: _____Group Name of ID#:_____
** The following is **REQUIRED** if the insured is not the subscriber of the insurance.
Name of Subscriber: _____Subscriber's ID#: _____
Subscriber's SSN#: _____/_____/_____ Subscriber's Date of Birth: _____/_____/_____
Relationship to insured: ___ Self ___ Mother ___ Father ___ Spouse ___ other

Signature:_____**Date:**_____ **please continue ⇒**

Spokane Allergy & Asthma Clinic & Clinical Research

NOTICE OF PRIVACY PRACTICE – ACKNOWLEDGEMENT

Dear Patient,

Health care practitioners have always protected the confidentiality of health information by sealing medical records away in file cabinets and refusing to reveal your information. Today, state and federal laws also attempt to ensure the confidentiality of this sensitive information.

The federal government recently published regulations designed to protect the privacy of your health information. This "privacy rule" protects health information that is maintained by physicians, hospitals, other health-care providers and health plans.

This new regulation protects virtually all patients regardless of where they live or where they receive their health care. Every time you see a health care practitioner, are admitted to the hospital, fill a prescription, or send a claim to a health plan, your practitioner, the hospital or other health –care provider will need to consider the privacy rule. All health information including paper records, oral communications, and electronic formats (such as e-mail) are protected by the privacy rule.

The privacy rule also provides you certain rights, such as the right to have access to your medical records. However, there are exceptions; these rights are not absolute. We also take precautions in our office to safeguard your health information such as training our employees and employing computer security measures.

This Notice of Privacy Practices attached to this letter explains our privacy practices. It contains very important information about how your confidential health information is handled by our office. It also describes how you can exercise your rights with regard to your protected health information. Please feel free to ask your practitioner about exercising your rights or how your health information is protected in our office.

By signing below, you acknowledge that you have received a copy of our Notice of Privacy Practices to read. If you would like a personal copy to take with you, you will be provided with one from the receptionist.

_____ _____

Patient Signature/(if under 18) Legal Guardian Signature Date

_____

Printed name if signed on behalf of the patient relationship to patient

****Please list any individuals we can discuss your medical information or your child's medical information with (ie. appointments, test results, treatment recommendations)

_____

Name relationship to patient

_____

Name relationship to patient

Spokane Allergy & Asthma Clinic

Michael Kraemer, MD Steven Kernerman, DO Kerry Drain, MD Ronald England, MD Cinda Reed, ARNP
508 W 6th Ste 700, Spokane WA 99204
Phone: 509-747-1624, Fax: 509-747-6774

Dear Patient and/or Parent/Guardian:

This form and your signature below serves as formal notification of our patient balance/billing policy.

We will bill your insurance company as a courtesy. If for **any reason** there is no response from your insurance company, you will get a bill from us and you will need to pursue this matter with your insurance company, and payment is expected to be paid to our office. The balances are usually for any unpaid medical services to you by our office, co-payments, co-insurance, information needed from the insured or member, non-met deductibles, non-covered services per your particular plan's benefits, pre-existing condition not payable by your insurance particular plan, or **no show/late cancellation fees.**

It is the policy of our office to send *only three statements.* The statements are sent at 25-day intervals. We will send you collection letters as well. If no payment is received on your account during the 75-day period, your account will be turned over to collections *without additional notice.* We feel that two months is a reasonable amount of time to make payments on your account.

For your convenience, accounts can be paid using your MasterCard or Visa. You can indicate your credit card information on the statement. You may also pay it over the phone using the credit cards listed.

FINANCIAL SERVICES:
We understand that there may be times when financial difficulties arise without warning. Under special circumstances, payment arrangements may be made. Accounts on a payment plan are required to make a payment each month. Missed payments could result in collections. Please contact our Billing Department at 509-747-1624 for any questions or to set up payment arrangements.

Your signature on this form acknowledges your understanding of this policy. Thank you for choosing Spokane Allergy and Asthma clinic for your medical care.

_____ _____

Patient Name (please PRINT) If patient is a minor, parent/guardian NAME

Patient Date of Birth: _____-_____-_____ Date: ____-____-____

Patient/Parent/Guardian SIGNATURE _____

Who may be contacted in the event of an emergency?

Name: _____ Phone: _____ Relationship: _____

May we leave personal information on your answering machine at home? ____ work? ___ cell? ___?
If yes, names of people we can give info to: _____

ASSIGNMENTS OF INSURANCE BENEFITS:
I assign all medical, surgical, immunology benefits to which I am entitled; private insurance and any other health plans to: ***SPOKANE ALLERGY AND ASTHMA CLINIC.*** This assignment shall remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original.

I understand that responsibility for payment of Medical Services in this office for myself or my dependants is mine, due and payable at the time services are rendered. I further understand that insurance is billed as a courtesy and I am responsible for any charges unpaid by the carrier.

I understand there is a *minimum* charge of $50.00 for **missed** appointments or appointments **not cancelled with at least 24 hours'** notice. **We Require 24-hour Notice to Cancel Appointments.**

Signature: _____ ***Date:*** _____

**** Financial Policy for MEDICARE PATIENTS *****

Please check one: I have paid my insurance deductible for the calendar year:
_____ Yes _____ No _____ Don't Know

MEDICARE PATIENTS ONLY:
I request payment of authorized Medicare benefits be made either to me or on my behalf to **Spokane Allergy and Asthma Clinic** for any services furnished to me by the listed provider/supplier.

I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in Item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the provider or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance, and non-covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

MEDICARE Patient's Name (Please Print): _____
MEDICARE Patient's Signature: _____
MEDICARE NO. _____ DATE: _____
PROVIDER: _____

SPOKANE ALLERGY AND ASTHMA CLINIC ALLERGY QUESTIONNAIRE

Please complete this questionnaire to have it available before your first office visit. This information is part of your medical record and will be treated confidentially. If some questions are not appropriate to your situation, move to the next section.

Patient's Name: _____ Birthday: _____ Consult requested by: _____

Name of Person Filling Out This Form: _____ Date of Visit: _____

What is your primary purpose for this allergy evaluation? _____

Who is your Primary physician: _____

What is your preferred pharmacy? _____

RESPIRATORY PROBLEMS

Please check YES ☒ for any current SYMPTOMS, or EXPOSURES THAT MAKE THESE SYMPTOMS WORSE. Leave these boxes blank if you do not feel that they have been a recurrent problem.

EYES	MOUTH, THROAT	EXPOSURES THAT MAKE THESE SYMPTOMS WORSE
☐ Itchy eyes	☐ Itchy throat	☐ Prolonged laughter
☐ Red eyes	☐ Sore throat	☐ House dusting
☐ Watery eyes	☐ Hoarse voice	☐ Wet or moldy areas
☐ Swollen, puffy eyes	☐ Frequent throat clearing	☐ Barns and hay
☐ Dry eyes	☐ Bad breath	☐ Springtime pollen
☐ Eye discharge		☐ Lawn mowing
☐ Eye drainage	**LUNGS**	☐ Cleaning solvents
☐ Other:	☐ Frequent daytime cough	☐ Irritating odors
	☐ Nighttime coughing	☐ Airborne chemicals
NOSE, EARS, SINUS	☐ Wheezing	☐ Wood smoke
☐ Post nasal drip	☐ Chest tightness	☐ Tobacco smoke
☐ Sneezing	☐ Chest pain	☐ Perfumes, air fresheners
☐ Nasal dripping and sniffling	☐ Shortness of breath	☐ Christmas trees
☐ Nasal congestion	☐ Exercise intolerance	☐ Latex rubber products
☐ Post nasal draining	☐ Recurrent bronchitis	☐ Cats
☐ Recurrent sinus infections	☐ Recurrent pneumonia	☐ Dogs
☐ Sinus pain/ pressure	☐ Other:	☐ Horses
☐ Mouth breathing		☐ Cattle
☐ Nighttime snoring	**EXPOSURES THAT MAKE THESE SYMPTOMS WORSE**	☐ Goats
☐ Nasal itching	☐ The spring months (March-June)	☐ Gerbils
☐ Increased frequency of colds	☐ The summer months (June-Aug)	☐ Guinea pigs
☐ Nosebleeds	☐ The autumn months (Sept-Nov)	☐ Hamsters
☐ Reduced ability to smell	☐ The winter months (Dec-Feb)	☐ Pet mice or rats
☐ Nasal polyps	☐ Crying or yelling	☐ Rabbits
☐ Itchy ears	☐ Very cold air	☐ Pet birds or feathers
☐ Dizziness	☐ Very hot and humid air	☐ Other:
☐ Ear "popping" or pressure	☐ Windy days, dust storms	
☐ Recurrent ear infections-otitis media	☐ Rainy days, wet weather	
☐ Middle ear fluid (effusions)	☐ Acquired viral URI's or "colds"	
☐ Diminished hearing	☐ Heartburn or acid reflux	
☐ Other:	☐ Exercise or running	

At what age did you first begin having these SYMPTOMS? _____

Have you ever had any Allergy Skin testing or blood testing for these problems? _____

Have you ever been treated with Allergy shots? _____

Names of any previous Allergy, ENT, or Respiratory specialists that you have seen: _____

SKIN, GASTROINTESTINAL AND FOOD-RELATED PROBLEMS

Please check YES ☒for any SYMPTOMS or EXPOSURES OR FOODS THAT MAKE THESE SYMPTOMS WORSE. Leave these boxes blank if you do not feel that they have been a recurrent problem.

SKIN	**GASTROINTESTINAL**	☐ Barley
☐ Dry skin	☐ Bloating	☐ Corn or corn by-products
☐ Scaly skin	☐ Recurrent nausea	☐ Rice
☐ Itchy skin	☐ Recurrent vomiting	☐ Peanuts
☐ Red and inflamed skin	☐ Recurrent heartburn	☐ Soybeans
☐ Eczema	☐ Regurgitation or reflux of food	☐ Green beans, navy beans
☐ Red, raised, itchy "hives	☐ Chest pains with swallowing	☐ Peas, lentils
☐ Deep tissue swellings	☐ Sticking of swallowed food	☐ Walnuts, pecans
☐ Recurrent blisters	☐ Recurrent abdominal pains	☐ Almonds, hazelnuts
☐ Contact allergic dermatitis	☐ Recurrent diarrhea	☐ Cashews, pistachios
☐ Recurrent skin infections	☐ Recurrent constipation	☐ Brazil nuts
☐ Hair loss	☐ Belching	☐ Pine nuts
☐ Other:	☐ Flatulence	☐ Mustard
	☐ Loss of appetite	☐ Sesame or poppy seeds
EXPOSURES THAT MAKE SKIN SYMPTOMS WORSE		☐ Flaxseed
☐ Cold weather or contact with ice	**SYMPTOMS RELATED TO EATING SPECIFIC FOODS**	☐ Sunflower seed
☐ Low humidity or dry weather	☐ Mouth and throat itching	☐ Buckwheat
☐ Contact with water or bathing	☐ Hives or rash only near the mouth	☐ Cod, salmon, halibut
☐ Overheating	☐ Abdominal cramping/pain nausea	☐ Shrimp, crab, lobster
☐ Exercise or sweating	☐ Widespread hives or rash	☐ Clams, oysters
☐ Scratching	☐ Worsening eczema	☐ Beef, lamb, pork
☐ Tight clothing, sustained pressure	☐ Other:	☐ Chicken, turkey
☐ Sustained vibration		☐ Apple, peach, cherry
☐ Sunlight	**FOODS THAT MAKE THESE SYMPTOMS WORSE**	☐ Berries
☐ Cosmetics	☐ Artificial food dyes	☐ Bananas
☐ Latex rubber (gloves)	☐ Wine, beer, alcoholic beverages	☐ Avocados
☐ Poison ivy/poison oak	Sulfites in foods	☐ Citrus fruits
☐ Contact with nickel in clothing	☐ Monosodium glutamate (MSG)	☐ Kiwi, mangoes, tropical fruits
☐ Metals in jewelry	☐ Cow's milk, ice cream, cheese	☐ Carrots
☐ Soaps, detergents	☐ Goat's milk	☐ Celery
☐ Perfumes	☐ Eggs	☐ Potatoes
☐ Creams or lotions	☐ Wheat	☐ Other:
☐ Topical antibiotics (neomycin)	☐ Oats	☐ Other:
☐ Topical eye drops	☐ Rye	☐

At what age did you first begin having these SYMPTOMS? _____

Have you ever had Allergy "Patch testing" done to confirm these sensitivities? _____

Names of anyprevious Dermatology or Gastroenterology (GI) specialists that you have seen: _____

STINGING INSECT REACTIONS (involving mosquitoes, bees, wasps, hornets, yellow jackets, fire ants, etc.)

Please check YES ☒ for any SUSPECTED INSECTS, SYMPTOMS, and REQUIRED TREATMENTS that have occurred with past stinging insect reactions. Leave these boxes blank if there has not been a prior reaction to insect stings.

SUSPECTED INSECTS CAUSING THESE SYMPTOMS	SYMPTOMS OCCURRING AFTER YOUR STING	TREATMENTS REQUIRED FOR THESE SYMPTOMS
☐ I do not know the type of insect	☐ Large localized swelling at the site	☐ Urgent care or clinic sick visit
☐ Honey bee	☐ Widespread rash (hives)	☐ Emergency room visit
☐ Bumble bee	☐ Swelling distant from the sting site	☐ Hospitalization
☐ Wasp	☐ Throat tightness, hoarseness	☐ Epinephrine injection
☐ Hornet (yellow)	☐ Cough, chest tightness, wheeze	☐ Intravenous fluids
☐ Hornet (bald faced)	☐ Abdominal pains	☐ Oral or injected antihistamines
☐ Yellow jacket	☐ Nausea, vomiting, diarrhea	☐ Oral or injected steroids
☐ Fire ant	☐ Lightheadedness, altered vision	☐ Other:
☐ Mosquito	☐ Lowered blood pressure, shock	☐ Other:
☐ Other:	☐ Other:	☐ Other:

At what age did you first begin having these sting reactions? _____

Have you ever had Allergy Skin testing or blood testing for this problem? _____

Have you ever been treated with Allergy shots for this problem? _____

Namesof any previous Allergy specialists that you have seen for this problem: _____

PREVIOUS MEDICATION REACTIONS

List any medications that have caused an adverse reaction. Describe the type of reaction (i.e. rash, or abdominal pain). Also, note your approximate age when this reaction occurred. Leave the boxes blank if you have not had a prior medication reaction.

MEDICATION NAME	TYPE OF REACTION	APPROXIMATE AGE
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		

ALLERGIC FAMILY HISTORY

Please check the box ☒ if other immediate family members have had a history of these problems

	Mother	Father	Brother 1	Brother 2	Sister 1	Sister 2	Other Relatives
Fill in this Person's Name							
Chronic Atopic Dermatitis or Eczema							
Food Allergies							
Allergic Nasal or Eye Symptoms							
Allergic or Non-allergic Asthma							
Recurrent Hives or Deep Swellings							
Recurrent Middle Ear or Sinus Problems							
Recurrent Migraine Headaches							
Insect Sting Allergies							
Other Health Issues:							

ENVIRONMENTAL EXPOSURES

Where were you born? _____ Where have you lived in your life? _____

_____ Where is your current home located? _____

In what year was your home built? _____ Number of people who currently occupy this home? _____

How many are adults? _____

Please check YES ☒ for the answers that best describe the basic structure, heating, cooling and filtering systemsfor this home. Leave the boxes blank if they do not relate to your current home.

What is the structure of your current home?	How do you currently heat your home?	How do you cool and/or filter your home?
☐ Single family home	☐ Electric baseboard heat	☐ Central air conditioner
☐ Condominium	☐ Electric wall heaters	☐ Window-insert air conditioner
☐ Duplex	☐ Steam radiators	☐ Opening the windows
☐ Apartment	☐ Hot water radiators	☐ Central humidifier
☐ Dormitory room	☐ Fireplace insert/woodstove	☐ Room-size humidifier
☐ Manufactured home	☐ Pellet stove	☐ Central air filter
☐ Trailer	☐ Propane stove	☐ Room-size air filter
☐ Lake cabin	☐ Gas forced air heat	☐ Fans
☐ Other:	☐ Electric forced air heat	☐ Other:
	☐ Heat pump	
	☐ Other:	

Please check ☒ if you have <u>ever used</u> tobacco products. Leave this section blank if you have never used tobacco products.

☐ For how many years did you use tobacco? _____ years. What type of tobacco product? _____ Cigarettes per day? _____

If you no longer use tobacco, what year did you quit? _____

If you still smoke, how many cigarettes do you smoke per day (on average)? _____ cigarettes/day

How many smokers currently live in this home? _____ Where do they smoke (circle the correct response): Indoors/ Outdoors/ Both

Please check YES ☒ for the most common air quality problems in your home. Also check YES ☒ for the animals that currently reside inside or outside your home. Leave the boxes blank if they do not apply to your current home.

WHAT ARE SOME POTENTIAL AIR QUALITY PROBLEMS?	INSIDE PETS/ANIMALS	OUTSIDE PETS/ANIMALS
☐ Indoor cigarette smoke	☐ Birds (number_____)	☐ Birds (i.e., chickens) (number____)
☐ Wood smoke	☐ Cats (number_____)	☐ Cats (number_____)
☐ Scented candles	☐ Dogs (number_____)	☐ Cattle (number_____)
☐ Incense odors	☐ Gerbils (number_____)	☐ Dogs (number_____)
☐ Irritating or noxious odors	☐ Guinea pigs (number_____)	☐ Goats (number_____)
☐ Excessive dampness	☐ Hamsters (number_____)	☐ Horses (number_____)
☐ Water damaged areas	☐ Pet mice (number_____)	☐ Llamas, alpacas (number_____)
☐ Moldy or musty odors	☐ Pet rats (number_____)	☐ Rabbits (number_____)
☐ Visible mold in some areas	☐ Rabbits (number_____)	☐ Sheep (number_____)
☐ Pet odors	☐ Reptiles: (number_____)	☐ Other:
☐ Other:	☐ Other:	☐ Other:

Current Work Exposures: (if applicable)

Where are you employed currently? _____

Job title: _____

Are there any workplace exposures that cause symptoms? _____

Current School Exposures: (if applicable)

What is the name of your school? _____ Grade: _____

Are there any school exposures that cause symptoms? _____

Current Daycare or Preschool Exposures: (if applicable)

What is the name of your daycare or preschool? _____

How many days/week do they usually attend this facility? _____ How many hours/day do they attend? _____

How many other children are at this facility (estimate)? _____

Are there any exposures here that cause symptoms? _____

List your Current Prescription and NonprescriptionMedication Names, including all topical ointments, creams, herbal remedies, and oral supplements. Write down the Usual Dosage and Frequency. For the Source of this Medication, include the name of the person providing this prescription, or write "OTC" if it is available "Over-The-Counter" or without prescription.

CURRENT MEDICATION NAME	USUAL DOSE AND FREQUENCY	SOURCE OF THIS MEDICATION (PRESCRIBER)
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		

PAST MEDICAL HISTORY/PAST SURGICAL HISTORY

Please check YES ☐ for any symptoms or surgeries you have had in the past. Leave these boxes blank if you feel these do not apply.

Medical History		
☐ Acid reflux	☐ Coronary artery disease	☐ Myocardial infarction
☐ Allergic rhinitis	☐ Depression	☐ Nasal fracture
☐ Allergies	☐ Deviated nasal septum	☐ Peptic ulcer disease
☐ Anemia	☐ Ear infections, acute	☐ Pleurisy
☐ Anxiety	☐ Ear infections, chronic	☐ Pneumonia
☐ Arthritis	☐ Eczema	☐ Renal disease
☐ Asthma	☐ Elevated lipids	☐ Seizure disorder
☐ Atopic Dermatitis	☐ Gallbladder disease	☐ Sinusitis
☐ Bronchitis	☐ GERD	☐ Sleep Apnea
☐ Cancer	☐ Headache, migraine	☐ Stroke
☐ Cardiovascular disease	☐ Headaches	☐ Tonsillitis
☐ Contact dermatitis	☐ Hepatitis/liver disease	☐ Tuberculosis
☐ COPD	☐ Hypertension	☐ Urticaria
		☐ Other:
Surgical History		
☐ Adenoidectomy	☐ Cholecystectomy	☐ Knee replacement
☐ Angioplasty	☐ Gastric bypass	☐ Myringotomy
☐ Appendectomy	☐ Hernia repair	☐ Thyroidectomy
☐ Back surgery	☐ Hip replacement	☐ Tonsillectomy
☐ Blood transfusion	☐ CABG	☐ Other:

OTHER SYMPTOMS

Please check YES ☒ for any SYMPTOMS you care experiencing currently. Leave these boxes blank if you do not feel that you are experiencing these symptoms.

CONSTITUTIONAL	**HEMATOLOGIC/LYMPHATIC**	**NEUROLOGICAL**
☐ Fatigue	☐ Lymphadenopathy	☐ Dizziness
☐ Insomnia	☐ Other:	☐ Fainting
☐ Malaise		☐ Headache
☐ Weight gain	**CARDIOVASCULAR**	☐ Seizures
☐ Weight loss	☐ Hypertension	☐ Other:
☐ Other:	☐ Arrhythmia	
	☐ Murmur	**PSYCHIATRIC**
METABOLIC/ENDOCRINE	☐ Edema	☐ Anxiety
☐ Decreased activity	☐ Syncope	☐ Depression
☐ Insomnia	☐ Palpitations	☐ Other:
☐ Diabetes	☐ Other:	
☐ Hypothyroid		**GENITOURINARY**
☐ Hyperthyroid	**REPRODUCTIVE**	☐ Urination at night
☐ Osteoporosis	☐ Pregnant	☐ Pain with urination
☐ Osteopenia	☐ Breast feeding	☐ Frequent urination
☐ Other:	☐ Post-menopausal	☐ Urinary incontinence
	☐ Other:	☐ Other:
MUSCULOSKELETAL		
☐ Joint pain		**IMMUNOLOGY**
☐ Joint swelling		☐ Recurrent infections
☐ Other:		☐ Other:

Who is your PRIMARY CARE PROVIDER? _____

List any other MEDICAL OR DENTAL SPECIALTY CONSULTANTS that you have seen: _____

_____

List any past HOSPITALIZATIONS that you have not yet mentioned (including the year):_____

_____

List any past SURGERIES that have been performed: _____

_____

List any significant PAST MEDICAL PROBLEMS. These are problems that are now RESOLVED, and require no further treatments or monitoring. List any past CANCER history here: _____

Is there any other question or concern that you would like to discuss with your Provider during this initial evaluation?_____

_____

Spokane Allergy & Asthma Clinic
508 W 6th Ave, Ste 700
Spokane Wa 99204
509 - 747-1624

COMING FROM THE NORTH:
Take Division into downtown. After you cross the river, get in the far right lane.
Follow this to Spokane Falls Boulevard. Now get in far left lane.
At Stevens Street, turn left.
Straight on Stevens through the next six lights, up the hill to 6th Avenue.
Our parking lot is on the SE corner of 6th and Stevens (on the left corner).
Our office building is on the NW corner of 6th and Stevens (on the right corner).

COMING FROM THE SOUTH:
Take Grand Boulevard, left lane. At Sacred Heart Hospital on 8th Avenue, turn
Left at the light (8th & McClellan) -- which then curves into Washington St, heading northward.
Stay left lane, ready to turn left at next light – on 6th Avenue.
Our parking lot is on 6th, between Washington and Stevens.
Our office building is on the NW corner of 6th and Stevens.

COMING FROM THE EAST:
From I-90, take exit 281 at Division Street – get in left lane.
You will be at 3rd Avenue. Go straight 1 block to 2nd Avenue, turn left.
On 2nd, stay in the left lane and go 5 blocks. Turn left on Stevens.
On Stevens, stay in left lane and go 4 blocks to 6th Ave. Turn left on 6th.
When you turn left, our parking lot is now on your right, at the SE corner.
Our office is on the NW corner of 6th & Stevens.

COMING FROM THE WEST:
From I-90, take exit 281 at Division Street – get in left lane.
Turn left at the light at the end of the off-ramp. Stay in the left lane.
Go straight to 2nd Avenue, turn left. On 2nd, stay in the left lane for
5 blocks, turn left on Stevens. On Stevens, stay in left lane and go
4 blocks to 6th Avenue. Turn left on 6th. When you turn left, our
parking lot is now on your right, at the SE corner. Our office is
on the NW corner of 6th & Stevens.

Our office is on the 7th floor, Suite 700 in the beige Qual-Med/Molina
Building. Handicapped parking available in front of our building – limited spaces.